

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - I-08

Subject: Improving the Medicare Economic Index

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Referred to: Reference Committee J
(Jack J. Beller, MD, Chair)

1 The Medicare Economic Index (MEI) is a measure of practice cost inflation that was developed in
2 1975 as a way to estimate annual changes in physicians' operating costs and earnings levels. As
3 the American Medical Association (AMA) continues to advocate for Medicare physician payment
4 updates that reflect increases in medical practice costs, the MEI provides a promising framework as
5 a measure for medical price increases. However, there are significant design flaws in the MEI that
6 should be addressed as the AMA continues its efforts to improve the Medicare physician payment
7 environment. Council on Medical Service Report 4-I-08, which is before the House at this
8 meeting, addresses emerging Medicare physician payment methodologies.

9
10 This report describes the MEI's use in the current physician payment system, and its composition,
11 and outlines opportunities for improvement. The Council met with principals of Health Policy
12 Alternatives (HPA), Inc. in March 2008 to discuss possible modifications to the current Medicare
13 physician payment system, which included a discussion of MEI shortcomings. The Council
14 gratefully acknowledges the work of HPA, and has included many of its conclusions in this report.

15 16 THE ROLE OF THE MEI IN PHYSICIAN PAYMENT

17
18 The MEI was intended to serve as a "cap" on physician fee increases. Prior to 1975, Medicare paid
19 physicians based on the physician's actual charge for a given service. Although payments were
20 subject to Medicare carriers' determinations of a "reasonable" charge, there was no set fee schedule
21 or benchmark that limited payment rates. Medicare determined the reasonable charge based on the
22 physician's individual claim history, and on similar claims from peer physicians. In the early
23 1970s, concern was growing about increasing Medicare costs, specifically rising Medicare
24 physician fees. In response to such concerns, Congress mandated the creation of a mechanism to
25 limit annual fee increases to increases in the costs of producing physician services and increases in
26 general earnings levels. This mechanism was the MEI.

27
28 Following its inception in 1975 (using 1973 benchmark data), the MEI served as the official
29 benchmark for physician payment increases. However, from 1984 until 1991, annual
30 Congressional action was required to set Medicare physician fee increases, because policymakers
31 were concerned that prices were rising too quickly even with the MEI limitation (CBO, September
32 2006). In 1992, Medicare adopted a single physician fee schedule based on the Resource Based
33 Relative Value Scale (RBRVS). Physician payments were to be updated annually based on the
34 MEI, plus the application of an adjustment factor (the Medicare Volume Performance Standard

1 [MVPS], predecessor of the Sustainable Growth Rate formula) designed to counteract increases in
2 the volume of services being delivered per beneficiary.

3
4 In 1998, the Sustainable Growth Rate (SGR) system replaced the MVPS as the mechanism to
5 ensure Medicare physician spending did not exceed expenditure targets. The SGR uses a targeted
6 growth rate based on gross domestic product growth, price changes, and changes in Medicare
7 enrollment and benefits. The MEI is used in the target calculation to determine the price
8 component of the SGR. The MEI is also the baseline for each year’s payment update calculation.
9 Payment updates are equivalent to the MEI multiplied by an “adjustment factor” that reflects how
10 spending compares to the SGR targets.

11
12 Payment updates also include a “productivity offset,” which reflects a downward adjustment to the
13 MEI intended to account for assumed physician productivity increases. In economic terms,
14 productivity growth describes an increased output of goods or services that can be attributed to
15 efficiency gains (e.g., more experienced workforce, better technology). The rationale for applying
16 a productivity adjustment to the MEI is that productivity gains are captured as part of the index
17 itself (i.e., through wage and benefit components, which tend to increase as productivity increases),
18 and they are reflected in the units of service (i.e., Relative Value Units [RVUs]) that physicians bill
19 (i.e., as productivity increases, physicians produce more RVUs). Applying a productivity offset to
20 the MEI when calculating Medicare payment updates “nets out” price increases associated with
21 productivity gains that would otherwise be double counted (i.e., counted once in the MEI, and once
22 in the number of RVUs produced).

23
24 Prior to 2002, the productivity offset was based on labor productivity, which had been showing
25 historically large increases and failed to reflect overall productivity trends. Due to strong advocacy
26 by the AMA and the Medicare Payment Advisory Commission (MedPAC), the Centers for
27 Medicare and Medicaid Services (CMS) changed the methodology for calculating the offset, and
28 now uses the ten-year moving average in economy-wide multi-factor productivity to determine the
29 offset. This change resulted in a 0.7% increase in the MEI in 2003 and, according to AMA
30 estimates, similar increases in subsequent years.

31 32 COMPOSITION OF THE MEI

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34 The MEI measures the weighted average of annual price changes for various inputs needed to
35 produce physician services. It is not intended to measure changes in practice costs, per se (e.g.,
36 changes in the number of employees; increases in technology investments). The index uses base
37 weights from the year 2000, and is comprised of values that measure physician earnings (52% of
38 the index) and practice expenses (48% of the index). Within each of these broad categories, price
39 proxies are identified for specific inputs, such as physician time, clinical and clerical staff, office
40 space, medical equipment, and professional liability insurance. Weights for the categories and sub-
41 categories are based on AMA physician surveys last conducted in 2001, and on data from the US
42 Census Bureau and the Bureau of Labor Statistics (BLS). Price proxies are derived primarily from
43 data from the BLS.

44
45 Current CMS policy is to update the MEI approximately every five years, with the next update
46 expected in the next couple of years (the last update was in 2004). The update process involves
47 resetting the MEI’s base year against which price increases are measured, and reevaluating the
48 expense categories, weights and price proxies based on the most current information available.

1 The AMA is in the process of conducting a Physician Practice Information Survey and expects that
2 the updated practice cost data obtained from the survey will be used by CMS in the next MEI
3 update.
4

5 According to MedPAC, “policymakers can use indexes to set payment rates that provide desirable
6 incentives to providers. Rates should not encourage providers to produce too many or too few
7 services or respond with actions detrimental to the government or beneficiaries” (MedPAC, March
8 2002). CMS uses different indexes for each Medicare fee-for-service program, reflecting
9 differences in the relative importance of cost components and in the choice of price proxies among
10 provider groups. Besides the MEI, other indexes include:

- 11
- 12 • The hospital market basket for operating costs in the inpatient and outpatient prospective
13 payment systems (PPS);
- 14 • The capital market basket for capital costs in the outpatient PPS;
- 15 • The exempt-hospital market basket for hospitals exempt from the inpatient PPS; and
- 16 • The skilled nursing facility market basket for the PPS for skilled nursing facilities.
17

18 Not all of the indexes are constructed or applied in the same way, however, and physician
19 payments are subject to greater limitations than those for other provider groups.
20

21 LIMITATIONS OF THE MEI 22

23 The MEI offers some promise as a mechanism to ensure that changes in physician practice costs
24 are recognized and adjusted for in physician payment rates. The index was specifically designed to
25 reflect specific cost increases associated with medical practice, and could be a valuable tool to help
26 ensure adequate physician payment rates under a future Medicare payment update system.
27

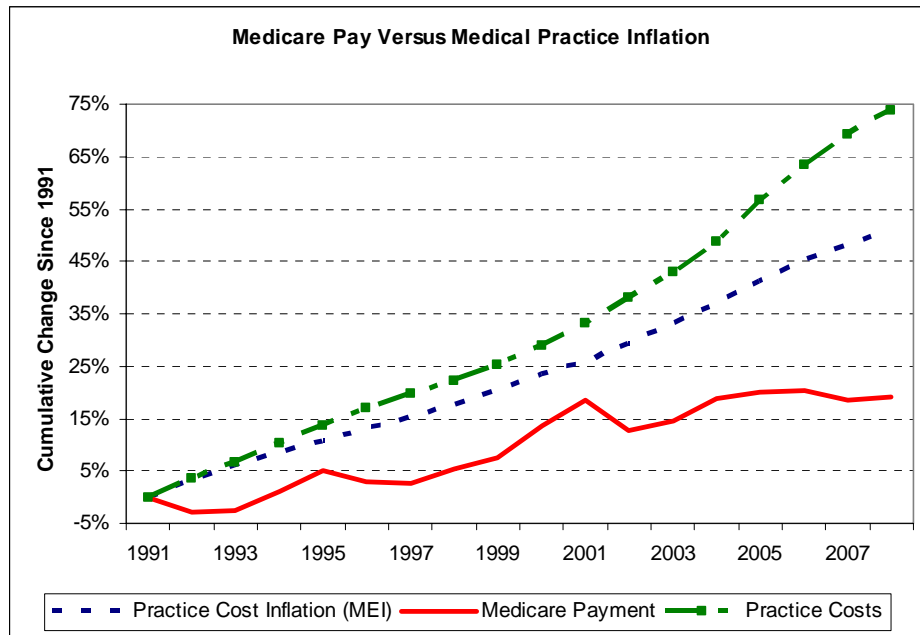
28 However, there are several limitations to the MEI as a reliable measure of medical cost inflation.
29 Table 1 on page 4 of this report shows cumulative changes in the MEI compared with estimates of
30 physician practice costs (based on data from the Medical Group Management Association), and
31 Medicare physician payments.
32

33 Even if the MEI were not diluted by the SGR formula (as reflected in the Medicare payment line),
34 changes in practice costs have consistently exceeded MEI, raising questions about the index’s
35 accuracy as a measure of medical cost inflation.
36

37 There is some concern that the price proxies used for various components of the MEI may not be
38 the most relevant metrics for estimating changes in practice costs. For example, CMS uses price
39 changes for all non-farm workers in the economy as a proxy for physician income, despite the fact
40 that BLS data are available for all professional and technical workers. Similarly, the price proxy
41 for employee compensation uses an index that holds skill mix constant, despite the fact that the
42 skill mix of nurses and technical assistants has likely increased. In addition, the MEI uses housing
43 rentals, rather than commercial rental costs, as a proxy for office rental rates. The appropriateness
44 of the price proxies used for the MEI is critical to ensuring it is a fair estimate of changes in
45 practice costs over time.

1 The actual inputs used to compose the index, and the weights assigned to those inputs, are also
 2 important in determining the MEI’s value as a measure of increases in practice costs. Although the
 3 MEI has been rebased and revalued since its creation, the actual composition of the inputs
 4 themselves has not changed to keep pace with the way medicine is practiced today. For example,
 5 the number of staff needed per physician has risen dramatically since the 1970s, but the MEI looks
 6 only at increases in wages and benefits, not the number or type of staff employed. In addition, the
 7 MEI does not explicitly capture costs associated with compliance with emerging legal and
 8 regulatory mandates, such as those intended to eliminate fraud, prevent billing errors, improve
 9 quality and patient safety, and meet the needs of disabled or non-English speaking patients.

Table 1

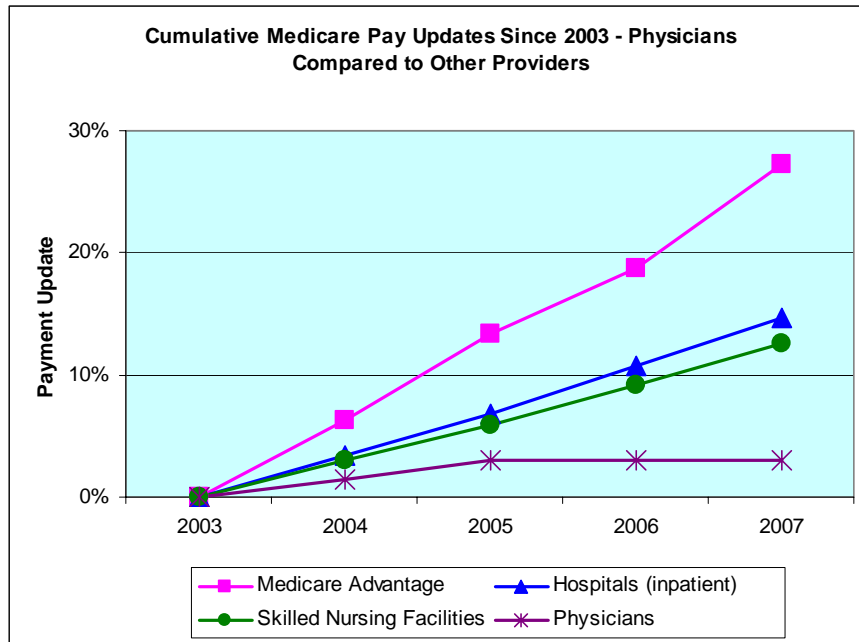


Source: AMA Division of Economic and Health Policy Research

8 Separate from the construction of the MEI itself is the concern about the application of the
 9 productivity offset. Medicare’s other price indexes do not include an automatic productivity
 10 adjustment, so physicians are disadvantaged during the update process relative to hospitals and
 11 other providers. As an example, CMS estimated that the price of goods and services used in
 12 physician practices increased 3.2% in 2008. However, after the application of a 1.4% productivity
 13 adjustment, the MEI rose only 1.8%; the adjustment automatically reduced the annual inflation
 14 update by nearly half. In contrast, the hospital market basket, which has no regular productivity
 15 adjustment, rose by 3.3%. Table 2 on page 5 of this report shows how recent physician payment
 16 updates have compared with other providers.

17
 18 In addition, productivity gains in health care have not generally matched those in the economy as a
 19 whole, so the use of a productivity offset based on economy-wide productivity is an unrealistic
 20 goal for physicians and other health care providers. There is general agreement that there is no
 21 good measure of physician productivity available today, and the best way to construct such a

Table 2



Source: AMA Division of Economic and Health Policy Research

1 measure is uncertain. However, as noted previously, the fact that physicians are automatically
 2 subject to significant productivity offsets, whereas adjustments are discretionary in updates for
 3 other provider groups, makes it important that CMS reevaluate the productivity goals and
 4 assumptions used with the MEI.

5

6 RELEVANT AMA POLICY

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8 Long-standing AMA policy recognizes the need to ensure that Medicare payment updates reflect
 9 physician practice cost increases. Policy H-400.966 (AMA Policy Database) calls for the AMA to
 10 promote the compilation of accurate data on all components of physician practice costs and the
 11 changes in such costs over time, and to work to improve the accuracy of such indexes of market
 12 activity as the MEI. Policy H-400.972[12] supports Medicare payment schedule conversion factor
 13 updates reflective of changes in physician practice costs, which could be calculated using an
 14 improved MEI. Among the several policies that call for the elimination or replacement of the SGR
 15 system, Policy H-390.855 specifically calls for it to be replaced with payment updates that reflect
 16 increases in the cost of medical practice.

17

18 DISCUSSION

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20 Problems associated with the current MEI – including unrealistic estimates of practice costs, and
 21 productivity adjustments – are symptomatic of larger problems in the Medicare physician payment
 22 system. The Council believes it is important that the AMA continue to advocate for improvements
 23 in the MEI, in the event that it becomes the basis for future payment update methodologies.

1 Existing AMA policy and ongoing advocacy efforts emphasize the importance of ensuring that the
2 MEI offers an accurate measurement of changes in physician practice costs. The use of
3 inappropriate price proxies, cost categories, or value weights have the potential to systematically
4 devalue physician incomes and practice expenses. The Council believes that the AMA should
5 continue to support improvements in the accuracy of the MEI.

6
7 CMS should also reexamine the use of the productivity offset applied to the MEI. The Council
8 believes that physicians should not be subject to automatic productivity adjustments. MedPAC and
9 Congress are currently able to exercise discretion with other provider groups, making a
10 productivity adjustment as appropriate in any given year based on specific circumstances. If a
11 productivity offset continues to be applied to the MEI, CMS should develop and use a productivity
12 measure that is specific to the physician or medical sector rather than assuming that economy-wide
13 productivity changes are representative of the health sector.

14
15 With the AMA's continued advocacy to repeal the SGR, and the emerging changes in physician
16 payment policy, the Council believes it is time for the AMA to renew its commitment to
17 advocating for improvements in the MEI to ensure that it can be a valuable tool for physicians and
18 policymakers.

19
20 RECOMMENDATIONS

21
22 The Council on Medical Service recommends that the following be adopted and the remainder of
23 the report be filed:

- 24
25 1. That our American Medical Association reaffirm Policy H-400.966, which calls for the AMA
26 to promote the compilation of accurate data on all components of physician practice costs and
27 the changes in such costs over time, and to work to improve the accuracy of such indexes of
28 market activity as the MEI. (Reaffirm HOD Policy)
29
30 2. That our AMA urge the Centers for Medicare and Medicaid Services and the Medicare
31 Payment Advisory Commission to review the MEI productivity offset and consider eliminating
32 it or revising it so that it more accurately reflects the effects of productivity increase in medical
33 practice. (Directive to Take Action)

Fiscal Note: Staff cost estimated to be less than \$500 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.